

6.0 ANALYSIS OF SERT DATA: IMPROVING QUALITY

Section 5.0 introduced basic expectations for local SERT processes and introduced online and offline reports that break data up into manageable pieces. The next steps of analysis involve studying reports to identify opportunities for improvement and determine what actions to take.

6.1 Report examples: CDDP processes

The online Overdue County Reviews report ([Figure 5.12](#)) provides details concerning overdue reviews; the online Overdue Investigations report ([Figure 5.10](#)) provides details concerning overdue investigations not referred to police; and the online Overdue Investigations Referred to Police report ([Figure 5.11](#)) provides details concerning overdue investigations that have been referred to police. Offline reports available from the Microsoft Access SERT database template can also help. The following are a few examples.

6.1.1 Completed CDDP SERT reviews

[Figure 6.1](#) shows information about County SERT reviews conducted to date for a specified year. This report shows that during 2004 this CDDP completed reviews of 121 incidents. The fewest number of days required to complete a review of an incident was 7; the most number of days required to complete a review was 136; the average number of days required to complete a review was 31; and the standard deviation for number of days to complete a review was 20. Fifteen of the completed reviews were late (completed more than 45 days after the incident was reported to the County); thus, 12% of the completed reviews were late.

6.1.2 Days required to complete SERT reviews

[Figure 6.2](#) is a histogram showing a “picture” of the number of days required by the CDDP to complete its reviews of incidents. The report shows that during the year 2004, no CDDP reviews of incidents were completed in fewer than 5 days after the incident was reported to the CDDP; 14 incident reviews were completed within 5 to 10 days after the incident was reported to the CDDP; 16 incident reviews were completed within 41 to 45 days, and so on. One incident review required more than 90 days to complete.

The reports depicted in [Figures 6.1](#) and [6.2](#) show SERT data *entered to date* for the specified year. By producing these reports at regular intervals a CDDP may quickly identify problems and initiate actions to improve review processes.

The Microsoft Access SERT database template also provides similar reports regarding investigations (see examples in [Figures 6.3](#) and [6.4](#)).

6.2 Report examples: Provider processes

The reports below allow a team to “drill down” into the data to discover more about incidents by site vs serious events by site. (Remember that a single incident may involve multiple serious events.)

6.2.1 SERT incidents by site

[Figure 6.5](#) is one page of a multi-page offline report showing the number of incidents experienced by people served by each CDDP provider site that has submitted at least one incident. The data are organized by month across an entire year to date. The report presents data in descending order (i.e., the provider sites named in the most reports are listed first). The report also shows the percentage of CDDP incidents accounted for by a single site, as well as the cumulative percentage accounted for by multiple sites. In this example, people served during 2004 at 548 Davie Street (a site affiliated with a provider named Ellison, Inc.) experienced 8 incidents. Those 8 incidents accounted for 5% of all incidents in the year. Six sites (548 Davie Street, 357 Mayo Street, 2548 Cashmere Way, 29 Brown Lane, and 2999 Carthage St.) accounted for 20% of the incidents. Three sites are affiliated with a single provider named Zeus Inc.

6.2.2 Serious events by site

[Figure 6.6](#) is one page of a multi-page offline report showing a similar report. [Figure 6.5](#) provided information about *incidents*, but Figure 6.6 provides information about *serious events*.

6.3 Report examples: Levels of Analysis and Action

Analysis of SERT data can occur at different “levels”, e.g.: by individual, by site, by provider agency, and by CDDP. These levels of analysis help determine whether action must be directed toward a single person, a single site, a single

provider agency, or multiple provider agencies experiencing the same problem. For example, the following offline reports could be produced regularly and reviewed to help the CDDP be sure that necessary action has been taken related to particular individuals.

6.3.1 County Review of Serious Events

[Figure 6.7](#) shows the first page of a 7-page “County Review of Serious Events” (i.e. all incidents that are not being investigated) report for which the Incident Date fell on or between 11/01/2004 and 11/30/2004. The report *also* shows all county review incidents with *outstanding (uncompleted) follow-ups*, regardless of the date on which the incident occurred.

6.3.2 County Review of Serious Events (“Late Entries”)

A “Late Entry” report may be helpful to capture incidents entered into the online database too late to be reviewed during their typical review period. For example, a CDDP SERT Team meets on December 15, 2004 to review all incidents that occurred during the previous month between 11/01/2004 and 11/30/2004 and that were entered into the online SERT database by 12/10/2004. The Team may also decide to include incidents for that period that were entered too late in SERT to have been reviewed at the *previous* monthly meeting, i.e. were entered into the SERT database *after* 11/10/2004. The report depicted in [Figure 6.8](#) can ensure those incidents don’t get lost. This report shows two incidents that occurred on or between 10/01/2004 and 10/31/2004, but were entered into the SERT database after 11/10/2004 (the date of the last monthly SERT Team meeting in the example).

6.3.3 Investigations

[Figures 6.9](#) and [6.10](#) depict similar reports for incidents that are being investigated, rather than being reviewed by the CDDP.

6.4 SERT licensing and certification information

SPD Licensing and Quality of Care enters information in the online SERT database about providers with significant health, safety and rights concerns affecting the licensing or certification process. (See [Enter New Purple Sheet](#) and [Purple Sheet List](#).) Each CDDP can access this information about its providers by selecting “View Licensing Citations” on its [SERT Home Page](#).

6.5 Putting It All Together

Despite differences in how CDDP’s implement SERT processes, the basic responsibilities for each SERT team are the same: **ANALYZE** the data, **ACT** on the information, and **RECORD** action taken and outcomes of action taken.

6.5.1. Data analysis

SERT teams review reports to learn about individual or system trends, issues, or licensing violations that require follow-up. Typical reviews address:

1. **Trends**: What types of events occur and how frequently do they occur? Are there positive or negative trends? (**Tips**: A minimum of 5 data points going in the same direction---up or down—may indicate a trend. For example, if there were 3 financial abuse allegations in a specific provider site in March, 5 in April, 8 in May, 12 in June, and 17 in July, the CDDP would be observing a trend.)
2. **Unusual patterns**: Are there holes or spikes in the data? For example, if the CDDP generally only has 3-4 incidents involving hospitalization and in one month there were 15---why was that?
3. **High frequency**: Do recurring incidents involve one Individual? Site? Provider? Type of incident throughout the whole county?
4. **Licensing or certification issues**: Has the CDDP been notified by SPD of any local programs with licensing violations? What type of violations? Do citations based on harm or potential for harm involve abuse? Are incident type and frequency consistent with what the CDDP knows of the agency’s performance?
5. **Reporting issues**: Do any programs appear to be under-reporting? How is the CDDP learning about incidents?
6. **Deaths**: Did deaths occur? Are those deaths currently being reviewed or investigated?

7. **Investigation and review outcomes/process:** How many investigated events resulted in substantiated, not substantiated or inconclusive outcomes? Is there a pattern or an increase in the number of substantiated allegations of abuse? How long does it take to complete investigation and review processes?

6.5.2 Acting on Information

Each SERT team acts to improve health and safety in services and in CDDP processes and then reviews the outcomes of those actions. Examples of typical SERT team actions include:

1. **Training or technical assistance to respond to a noticed trend.** For example, providing training on proper financial management of client funds in response to a trend of incidents involving mishandling of client money.
2. **Monitoring plans of improvement.** See that programs facing licensing problems turn in a plan of improvement and follow up by overseeing implementation within a prescribed time frame.
3. **Adjusting individual supports.** Review Individual Service Plan (ISP) or specific interventions (such as a behavior support plan) when an individual is continually involved in a particular kind of incident or an increasing number of incidents.
4. **Recommendations.** Provide programs with written recommendations with definitive completion dates.
5. **Adjusting procedures.** If incidents are not being reviewed in a timely manner or investigations are not being completed in a timely manner, develop or revise strategies for improving timeliness.
6. **Seeking assistance.** Explore options for technical assistance, training, special reviews or other assistance through SPD or other sources.

6.5.3 Recording actions and outcomes

SERT teams record action taken to improve services and processes. This record must include a description of the issue or problem addressed, recommended action, action taken, responsible person(s), timelines, any follow-up required, and outcomes of the action. Both immediate and long-term outcomes are included in the record. For example, when a SERT team notices a trend of increasing incidents of financial exploitation or mismanagement, the action taken might be to implement training for providers on setting up financial records and making a financial plan. The *immediate* outcome may be that 120 people complete the training. The *long-term* result may be that financial exploitation incidents drop by 20%.

6.6 Monthly CDDP SERT Review

The Monthly CDDP SERT Review is the local SERT team's report to SPD (see [Section 5.2.1](#)).

6.6.1 Report format.

SPD does not require a standard format for [Monthly CDDP SERT Reviews](#), but the reports must include evidence of data analysis, issue review, actions taken, and outcomes of actions taken. An [example report format](#) is available at the end of this manual that meets SPD requirements for content.

6.6.2 Submitting the Monthly CDDP SERT Review

Monthly CDDP SERT Reviews must be uploaded to SPD according to timelines given in Section 5 ([Table 5.2.2](#)). Here is a convenient way to upload the reports:

1. Open up a blank WORD document and minimize it.
2. Open up Internet Explorer and login to SERT.
3. Go to the SERT "Home Page" for the county.
4. Look under SERT Quick Picks – Online Forms County Monthly SERT Review Report template **Word**. Click on **Word**. This will pull up the template in Microsoft-Word.
5. Fill out the information. Save the document with a new file name to a directory of user's choice, then minimize the document. This will be the document to upload. (File name example: Lincoln-2003-0402 saved to C:).
6. Return to the [SERT Home Page](#) for the CDDP and click "Submit County Monthly SERT Review". Click **Browse** button and locate file saved to upload. Double click the file-name. It will appear in the **Form to upload** space. Click "Upload File" button.

6.7 What happens outside the CDDP?

SPD personnel periodically review Monthly CDDP SERT reports looking for regional trends and trends across providers with sites in multiple counties. The state SERT team meets regularly to review and act on information from these

reports, the SERT database, licensing and certification records and the Office of Investigations and Training. This process is similar to the CDDP review, although its focus is on regional and statewide trends and issues. Notes of the meetings are available through each CDDP's **SERT Home Page**; simply click on "State SERT Team Minutes".

State Review Process

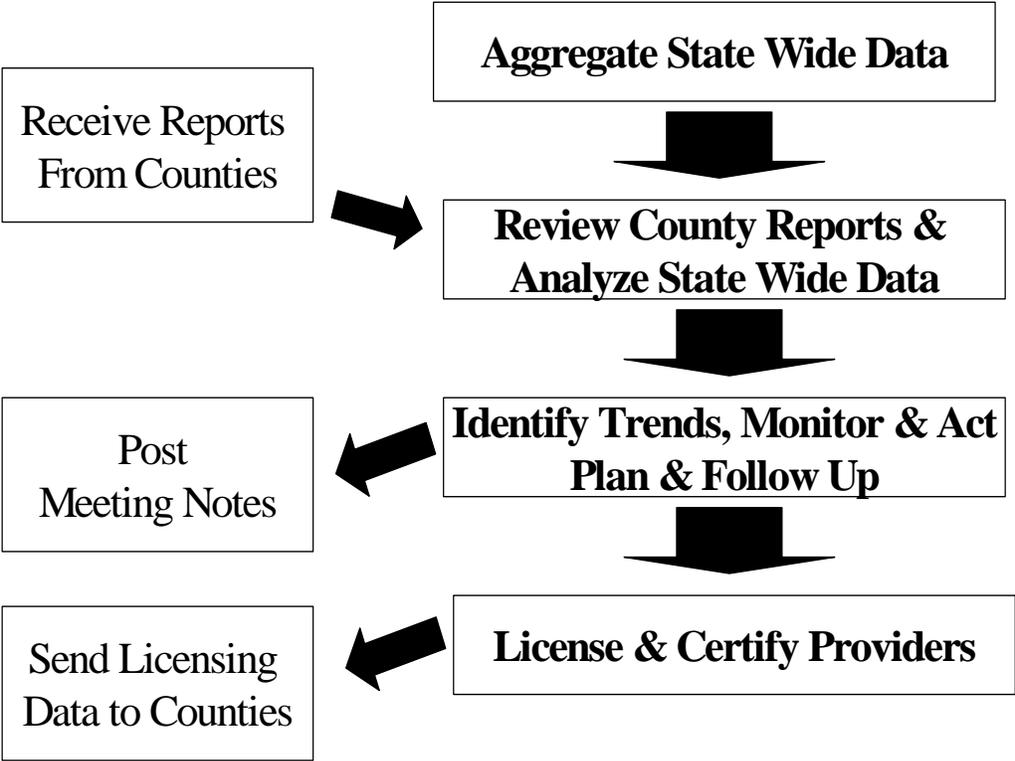


Figure 6.1

Figure 6.1

1.2 Completed County SERT Reviews

(Notes - "Days to complete a review" is measured as:

The date the County review was completed, minus the date the incident was reported to the County.

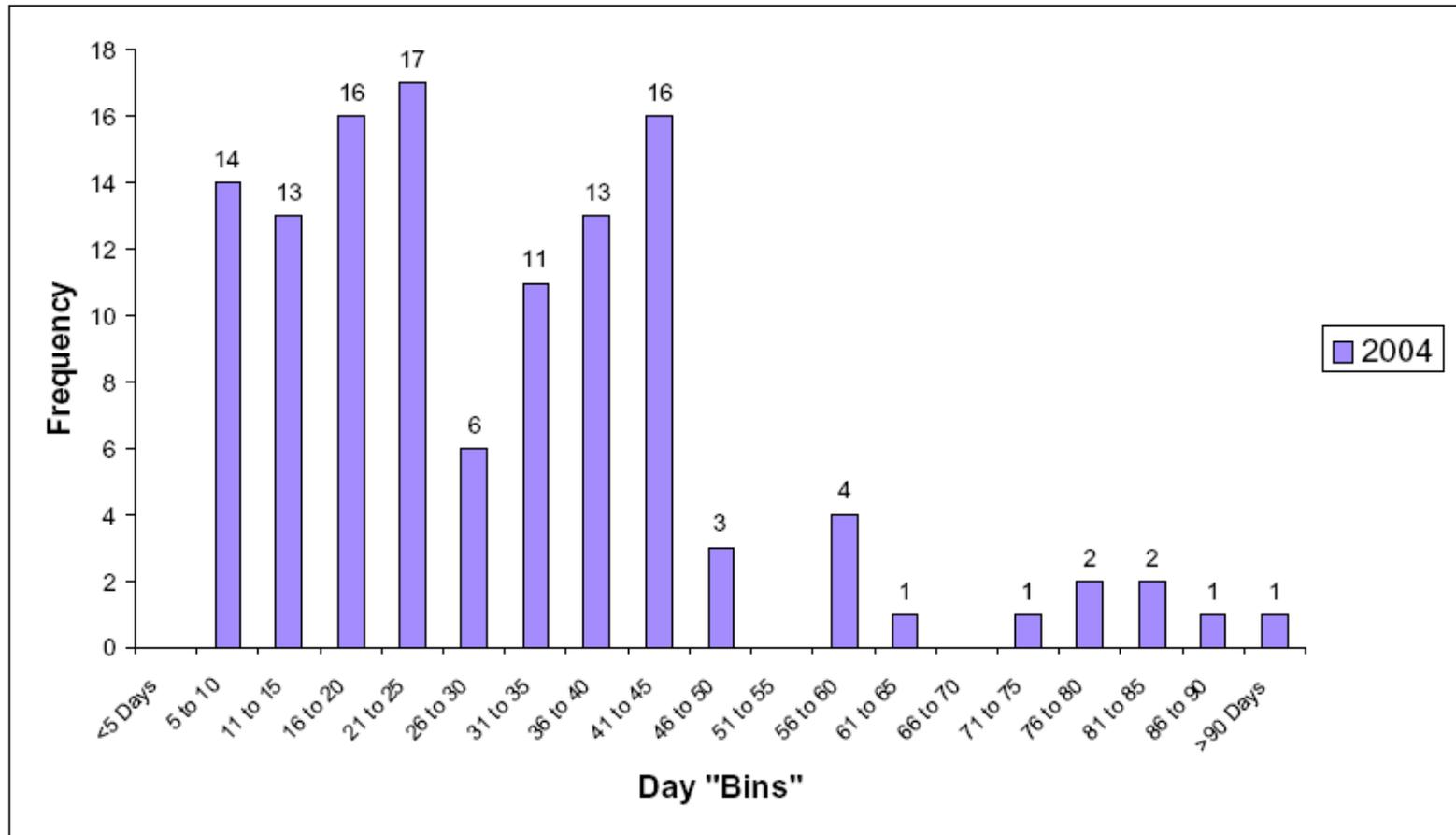
"Late" reviews are reviews completed more than 45 days after the date the incident was reported to the County.)

<i>Year</i>	<i>No. of Reviews</i>	<i>Fewest No. of Days to Complete a Review</i>	<i>Most No. of Days to Complete a Review</i>	<i>Average No. of Days to Complete a Review</i>	<i>StDev for No. of Days to Complete a Review</i>	<i>No. of Late Reviews</i>	<i>% of Reviews that were late</i>
2005	2	13	33	23.00	10.00	0	0%
2004	121	7	136	30.80	19.99	15	12%
2003	107	3	124	35.24	23.65	22	21%

Figure 6.2

Figure 6.2

7.6 Days Required to Complete SERT Reviews



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Report 7.6 rptRevCompHistogram

Figure 6.3

Figure 6.3

2.2 Completed SERT Investigations

(Notes - "Days to complete an investigation" is measured as:

The date the investigation was completed, minus the date the incident was reported to the County.

"Late" investigations are investigations completed more than 45 days after the incident was reported to the County.)

Year	No. of Investigations	Fewest No. of Days to Complete an Investigation	Most No. of Days to Complete an Investigation	Average No. of Days to Complete an Investigation	StDev for No. of Days to Complete an Investigation	No. of Late Investigations	% of Investigations that were late
2005	2	23	35	29	6.00	0	0%
2004	36	24	268	98	54.16	26	72%
2003	22	22	161	65	35.99	13	59%

Figure 6.4

Figure 6.4

7.8 Days Required to Complete Investigations

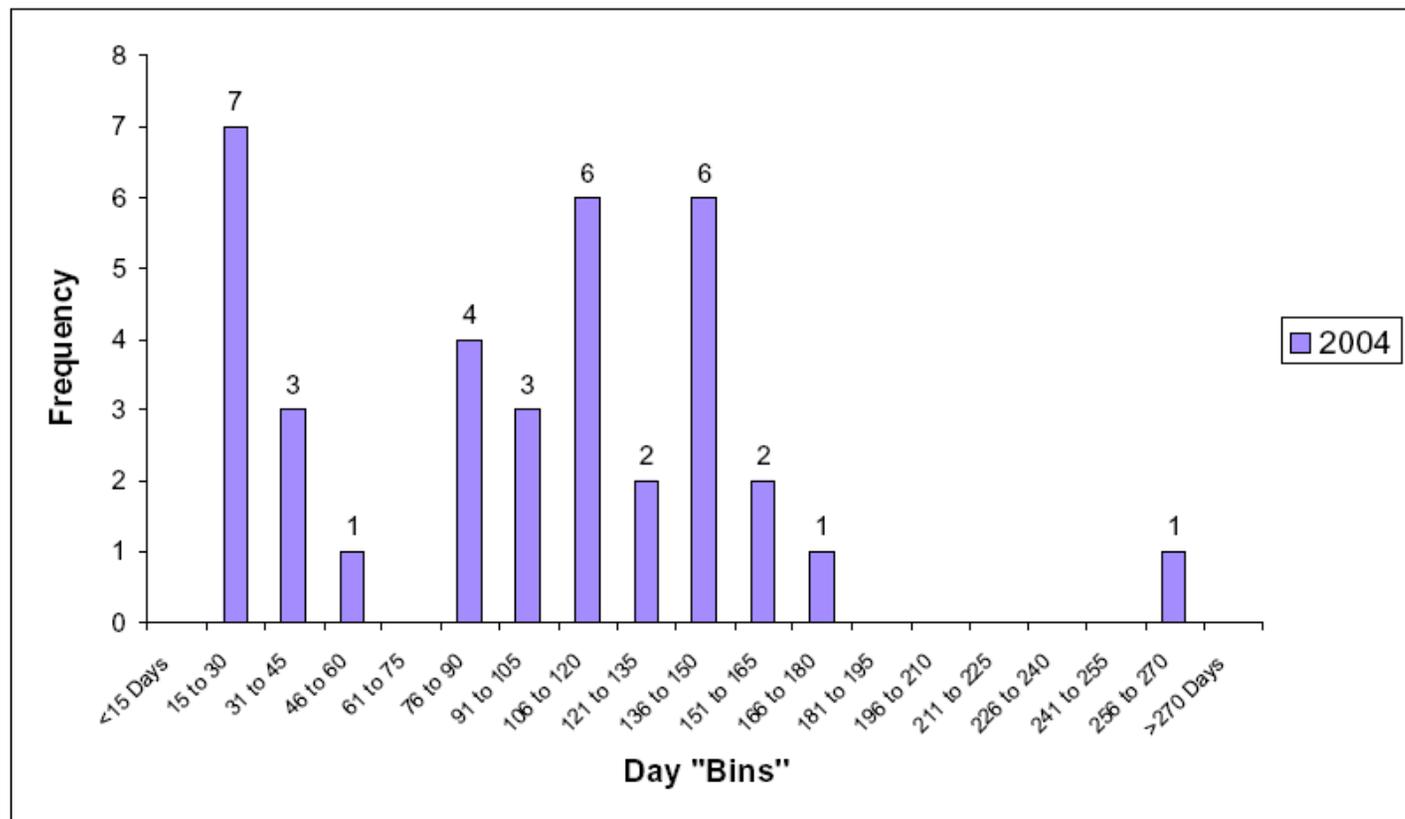


Figure 6.5

Figure 6.5

3.3 SERT Incidents by Site

Year	Line#	Site	Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	%	Cum. %
2004	1	548 Davie Street	Ellison Inc.	0	0	0	1	0	1	3	0	0	0	2	1	8	5%	5%
	2	357 Mayo Street	Zeus Inc.	0	0	0	0	0	0	0	1	0	1	2	3	7	4%	10%
	3	2548 Cashmere Way	Zeus Inc.	0	0	2	5	0	0	0	0	0	0	0	0	7	4%	14%
	4	29 Brown Lane	Foster Care	1	2	0	0	0	0	0	0	0	0	0	0	3	2%	16%
	5	2999 Carthage St.	Zeus Inc.	1	0	0	0	0	0	2	0	0	0	0	0	3	2%	18%
	6	148 Yerington Street	Coleridge Inc.	0	1	0	1	0	0	0	1	0	0	0	0	3	2%	20%
	7	298 Garcia Way	Zeus Inc.	0	0	1	0	0	1	1	0	0	0	0	0	3	2%	22%
	8	876 Harvest Road	Foster Care	0	0	0	2	0	0	0	0	0	0	0	0	2	1%	23%
	9	125 Jackpot Place	Dante Inc.	0	0	0	0	0	0	0	0	0	0	2	0	2	1%	24%
	10	148 Lovelock Road	CDDP (CM Services Only)	0	0	0	0	0	0	0	1	1	0	0	0	2	1%	26%
	11	2999 Misty Meadow	Foster Care	0	0	0	0	0	0	1	0	0	1	0	0	2	1%	27%
	12	124 Zephyr Cove Road	Peacock Inc.	0	1	0	0	0	0	0	1	0	0	0	0	2	1%	28%
	13	8390 Turner Avenue	Foster Care	0	0	0	0	1	0	0	0	0	0	1	0	2	1%	29%
	14	1569 ELKO STREET	Foster Care	0	0	0	0	0	0	0	0	0	0	0	2	2	1%	31%
	15	8888 Dillsboro St.	Foster Care	0	0	0	0	0	0	1	0	0	0	1	0	2	1%	32%
	16	368 Asheboro Blvd.	Goodale Inc.	0	0	0	0	0	0	1	1	0	0	0	0	2	1%	33%
	17	458 Oak Island Blvd.	Zeus Inc.	0	0	0	0	1	1	0	0	0	0	0	0	2	1%	35%
	18	93737 Misty Quail	Foster Care	0	1	1	0	0	0	0	0	0	0	0	0	2	1%	36%
	19	3849 Lazy Lane	Nursing Provider	0	0	0	0	1	0	0	0	0	0	1	0	2	1%	37%
	20	159 Arcadia	Lee Inc.	1	0	1	0	0	0	0	0	0	0	0	0	2	1%	38%
	21	287 Williams Way	Foster Care	0	0	0	0	0	0	1	0	0	0	0	0	1	1%	39%
	22	3269 Carlton Street	Zeus Inc.	0	0	0	0	0	0	0	0	1	0	0	0	1	1%	40%
	23	3269 Vashon Road	Lee Inc.	0	0	0	0	0	0	1	0	0	0	0	0	1	1%	40%
	24	387 Miller Blvd.	CDDP (CM Services Only)	1	0	0	0	0	0	0	0	0	0	0	0	1	1%	41%
	25	33 Troutman Blvd.	Illich Inc.	0	0	0	0	0	1	0	0	0	0	0	0	1	1%	42%
	26	34 Spring Valley	Foster Care	0	0	0	0	0	0	0	0	0	1	0	0	1	1%	42%

Figure 6.6

Figure 6.6

4.3 Serious Events by Site

Year	Line#	Site	Provider	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	%	Cum. %
2004	1	548 Davie Street	Ellison Inc.	0	0	0	2	0	1	3	0	0	0	4	1	11	5%	5%
	2	2548 Cashmere Way	Zeus Inc.	0	0	2	6	0	0	0	0	0	0	0	0	8	4%	9%
	3	357 Mayo Street	Zeus Inc.	0	0	0	0	0	0	0	1	0	1	3	3	8	4%	13%
	4	29 Brown Lane	Foster Care	3	4	0	0	0	0	0	0	0	0	0	0	7	3%	16%
	5	159 Arcadia	Lee Inc.	3	0	2	0	0	0	0	0	0	0	0	0	5	2%	19%
	6	125 Jackpot Place	Dante Inc.	0	0	0	0	0	0	0	0	0	0	5	0	5	2%	21%
	7	148 Yerington Street	Coleridge Inc.	0	1	0	2	0	0	0	2	0	0	0	0	5	2%	23%
	8	1569 ELKO STREET	Foster Care	0	0	0	0	0	0	0	0	0	0	0	4	4	2%	25%
	9	8888 Dillsboro St.	Foster Care	0	0	0	0	0	0	2	0	0	0	1	0	3	1%	27%
	10	148 Lovelock Road	CDDP (CM Services Only)	0	0	0	0	0	0	0	1	2	0	0	0	3	1%	28%
	11	2999 Carthage St.	Zeus Inc.	1	0	0	0	0	0	2	0	0	0	0	0	3	1%	30%
	12	298 Garcia Way	Zeus Inc.	0	0	1	0	0	1	1	0	0	0	0	0	3	1%	31%
	13	387 Miller Blvd.	CDDP (CM Services Only)	3	0	0	0	0	0	0	0	0	0	0	0	3	1%	33%
	14	368 Asheboro Blvd.	Goodale Inc.	0	0	0	0	0	0	1	2	0	0	0	0	3	1%	34%
	15	88888 Jefferson Street	Foster Care	0	0	0	0	0	0	3	0	0	0	0	0	3	1%	35%
	16	287 Williams Way	Foster Care	0	0	0	0	0	0	3	0	0	0	0	0	3	1%	37%
	17	93737 Misty Quail	Foster Care	0	1	2	0	0	0	0	0	0	0	0	0	3	1%	38%
	18	4848 Lula Collins Road	Foster Care	0	0	2	0	0	0	0	0	0	0	0	0	2	1%	39%
	19	3849 Lazy Lane	Nursing Provider	0	0	0	0	1	0	0	0	0	0	1	0	2	1%	40%
	20	458 Basin City Place	Zeus Inc.	0	0	0	0	2	0	0	0	0	0	0	0	2	1%	41%
	21	444 Fallong	CDDP (CM Services Only)	0	0	0	2	0	0	0	0	0	0	0	0	2	1%	42%
	22	258 Sedalia Way	Zeus Inc.	2	0	0	0	0	0	0	0	0	0	0	0	2	1%	43%
	23	654 Pace	Zeus Inc.	0	0	0	0	0	0	0	0	0	0	2	0	2	1%	44%
	24	397 Lazy Way	Foster Care	0	0	0	0	0	0	0	0	2	0	0	0	2	1%	45%
	25	458 Oak Island Blvd.	Zeus Inc.	0	0	0	0	1	1	0	0	0	0	0	0	2	1%	46%
	26	21597 Hawthorne Place	CDDP (CM Services Only)	0	0	0	0	0	0	0	2	0	0	0	0	2	1%	47%
	27	159 Arcadia	Quillen Inc.	0	0	0	0	0	0	0	0	0	2	0	0	2	1%	48%

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ptSEsBySite&Year

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Figure 6.7

Figure 6.7

6.1 County Review of Serious Events

(includes county review incidents that occurred between the specified date parameters, AND county review incidents with outstanding follow-ups, regardless of their incident date)

Incidents occurring between 11/1/2004 and 11/30/2004

No.	Inc. Date	ID	Case No.	Name	Provider	Incident Location	Description of Incident	
<u>1</u>	10/18/2004	2157	324	Chatman, Clinton	Foster Care	1548 Beatty Street	Clint had an aggressive incident at work. He was still upset when he returned to his foster home. The foster care provider was afraid and called the police. He acted aggressive toward the police, and was taken to the Mt. Pleasant Psychiatric Hospital.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes Yes</p>								
Date Review Completed		Recommendations for incident described above, if applicable				Follow-Up Required?		Date Follow-up Completed, if applicable
11/20/2004						Yes		
<u>2</u>	10/20/2004	2159	151	Spell, Lester	Foster Care	977 Mount Mitchell Way	Lester threatened his foster provider in the night. The police were called. Lester repeatedly threatened suicide. He was taken to Mt. Pleasant Psychiatric Hospital.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes Yes</p>								
Date Review Completed		Recommendations for incident described above, if applicable				Follow-Up Required?		Date Follow-up Completed, if applicable
11/10/2004						Yes		
<u>3</u>	10/25/2004	2178	135	Sloan, Stuart	Coleridge Inc.	98 Plantain	Stuart attacked another resident. Staff tried to calm him, but he began hitting himself and throwing furniture. He was taken to Friendly Hospital ER, where he received stitches.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes</p>								
Date Review Completed		Recommendations for incident described above, if applicable				Follow-Up Required?		Date Follow-up Completed, if applicable
11/10/2004						Yes		

Figure 6.8

Figure 6.8

6.2 County Review of Serious Events ("Late Entries")

(includes county review incidents that occurred between the specified date parameters, but were entered too late to have been reviewed at a previous meeting)

Incidents occurring between 10/1/2004 and 10/31/2004 but entered after 11/10/2004

No.	Inc. Date	ID	Case No.	Name	Provider	Incident Location	Description of Incident	
<u>1</u>	10/19/2004	2186	8	Staten, Lance	Foster Care	Highway 99, near Dobson city limits	Lance was visiting his sister. They had a car accident, and Lance was taken to the Friendly Hospital ER for treatment.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes</p>								
Date Review Completed		Recommendations for incident described above, if applicable				Follow-Up Required?		Date Follow-up Completed, if applicable
<u>2</u>	10/24/2004	2177	173	Burrow, Javier	Aaron Inc.	659 Cape Coral Road	Javier was getting ready to go home from his day program, when he got mad at a staff member for an unknown reason. Javier broke the pane of the fire extinguisher box with his left hand. He was transported to the Friendly Hospital ER, where he was treated	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes</p>								
Date Review Completed		Recommendations for incident described above, if applicable				Follow-Up Required?		Date Follow-up Completed, if applicable

Figure 6.9

Figure 6.9

6.3 Investigations (includes investigation incidents that occurred between the specified date parameters; ALSO includes completed investigations with unentered results and investigations with outstanding follow-ups, regardless of their incident date)

Incidents occurring between **11/1/2004** and **11/30/2004**

No.	Inc. Date	ID	Case No.	Name	Provider	Incident Location	Description of Incident	
<u>1</u>	2/8/2003	1843	139	Clough, Corey	Coleridge Inc.	8745 Trenton Street	Complainant reported a residential staff applied a "head lock" to Corey while trying to restrain him.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: right;">Yes</p>								
<i>Date Invest. Completed</i>		<i>Result</i>		<i>Outcome</i>		<i>Action</i>	<i>Follow-Up Required?</i>	<i>Date Follow-up Completed, if applicable</i>
3/20/2003		I		Does not meet the definition of abuse.			Yes	
<u>2</u>	2/11/2003	1841	318	Ambriz, Rosie	Coleridge Inc.	3267 Ocean Park Place	A staff person was witnessed roughly escorting Rosie to her room to change her clothes. While in the room, Rosie was yelling and trying to get out.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: right;">Yes</p>								
<i>Date Invest. Completed</i>		<i>Result</i>		<i>Outcome</i>		<i>Action</i>	<i>Follow-Up Required?</i>	<i>Date Follow-up Completed, if applicable</i>
4/8/2003		I		The investigation did not reveal any corroborating evidence related to the allegation. The investigation was inconclusive for unauthorized restraint.		Recommended the agency review AV's behavior support plan and have preferred staff working with AV if possible.	Yes	
<u>3</u>	3/15/2003	1842	239	Noah, Dona	Foster Care	87 Heather Ridge	Dona reported to vocational staff that her foster provider slapped her face and spanked her prior to Dona's leaving for work that morning.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: right;">Yes</p>								
<i>Date Invest. Completed</i>		<i>Result</i>		<i>Outcome</i>		<i>Action</i>	<i>Follow-Up Required?</i>	<i>Date Follow-up Completed, if applicable</i>
4/24/2003		I		There was no corroborating evidence to support the allegation. The investigation was inconclusive for willful infliction of pain.		Recommendation the foster providers receive mandatory abuse reporting training.	Yes	

Figure 6.10

Figure 6.10

6.4 Investigations ("Late Entries") *(includes investigation incidents that occurred between the specified date parameters, but were entered too late to have been reviewed at a previous meeting)*

Incidents occurring between 10/1/2004 and 10/31/2004 but entered after 11/10/2004

No.	Inc. Date	ID	Case No.	Name	Provider	Incident Location	Description of Incident	
<u>1</u>	10/10/2004	2158	171	Vo, Isaac	CDDP (CM Services Only)	14 William & Mary St.	It is alleged that Isaac's medical care had been neglected by his family. It was reported that Isaac has been showing signs of a severe toothache for two weeks, and his needs have not been addressed yet.	
<p>Amb CrimRef Death Emerg Finan Fire Hosp InjPain Neg PerFnd PhyAbu Pol PsyHos Restraint Restrict SexAbuse Verbal</p> <p style="text-align: center;">Yes</p>								
<i>Date Invest. Completed</i>		<i>Result</i>	<i>Outcome</i>	<i>Action</i>			<i>Follow-Up Required?</i>	<i>Date Follow-up Completed, if applicable</i>

Enter a new Purple Sheet
(for use by Licensing only)

Enter New Purple Sheet

DRAFT:

FINAL:

Service Type:

Agency:

Site Address:

Phone:

County:

License Exp. Date: 

Nursing Services: Yes No

How many people being served?:

Date of Review: 
(MM/DD/YYYY format or calendar)

Type of Review:

Follow up scheduled for 
(MM/DD/YYYY format or calendar)

Name of Licensing Spec and # of Records Reviewed & Name(s)

Problem:

500 Summer St NE, E-12 • Salem, Oregon 97301
PH: 1-800 282-8096 • Fax: (503) 373-7274 •
TTY: (503) 945-5933

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Seniors & People with Disabilities

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Purple Sheet List

Select the period from any one of these options:

- Last Month
- Last Two Months
- Since this date:
- Date Range:

August 18 2006

January 1 2000

January 1 2000

Get History

Entered by	Review Date	Provider	Draft	View/Print	Update
tritner	8/18/2006	RON WILSON CENTER 155 W Clay	Draft	View/Print	Update
cdavison	8/21/2006	RAINBOW ADULT LIVING 17816 SE Tibbetts		View/Print	Update
acoskey	8/22/2006	NATIONAL MENTOR SERVICES, LLC dba DSI 3033 NE Rodney		View/Print	Update
tritner	8/23/2006	COMMUNITY ACCESS SERVICES II, INC. 5405 SW 197th, Aloha		View/Print	Update
jransom	8/29/2006	COAST REHAB. SERVICES/COASTAL 65 N HWY 101, Warrenton	Draft	View/Print	Update